How to File

You may request MAP benefits by using the Medical Plan Claim Form or, if your expense is for prescription drugs and it qualifies for payment under MAP (see page 39), by using the Medical Plan Prescription Drug Claim Form. You may obtain Claim Forms by calling Blue Cross and Blue Shield of Alabama at 1-800-633-8915. A copy of the Medical Plan Claim Form is included in the **Forms** section of your BellSouth Employee Benefits binder. Reproduce it as needed for your use. When you call Blue Cross and Blue Shield of Alabama, a recording will ask a series of questions to which you will respond. Then your request will be processed. For obtaining information on prescription drugs through the Mail Order Prescription Drug Program or the PPO pharmacy network, see pages 40-43.

Medical Plan Claim Form

Your claim form must include:
- Employee's/Retiree's full name and contract number (BLS plus Social Security number) as shown on the BellSouth Medical Plan Identification Card;
- Spouse's employment and other medical coverage information;
- Patient's full name and date of birth;
- Date and place of service;
- Diagnosis/illness;
- Type of service;
- Amount of charges;
- Registration or license number of registered nurse or licensed practical nurse, when applicable.

Medical Plan Prescription Drug Claim Form

Your prescription drug claim form must include:
- The prescription number;
- The National Drug Code (NDC) provided by your pharmacist;
- Pharmacy name and address;
- Date filled;
- Whether your physician required a brand name instead of a generic substitute;
- Whether a generic substitute was available from your pharmacist;
- The quantity dispensed (e.g., "30 tablets");
- Your signature;
- Proof of purchase, such as the original or copy of an itemized receipt.

Providing Blue Cross and Blue Shield of Alabama with complete, accurate information as requested on the claim form helps assure that your claims will be processed in a timely manner. For reference, keep copies of your claim forms, bills and any other supporting records.

Mail the completed forms and itemized receipts to:

Blue Cross and Blue Shield of Alabama
BellSouth Dedicated Service Center
P. O. Box 830279
Birmingham, Alabama 35283-0279

How Benefits Are Paid

The following examples illustrate how MAP benefits are paid. In each example, assume the $180 deductible has been met. As a reminder, the QCP penalty is $250 for non-certification.

Example #1

The employee lives in a PPO area and uses a PPO hospital and PPO physician. The employee has surgery. (Deductible met)

	Charges	MAP Pays	Employee Pays	Applied to Out-of-Pocket
Hospital	3,000	3,000 (100% of covered charge)	- 0 -	- 0 -
Physician (surgery charge)	1,000	900 (90% of covered charge)	100	100
Total, if QCP Precertifies	4,000	3,900	100	100
Total, if not Precertified	4,000	3,650	350 (includes $250 penalty)	100

Example #2

The employee lives in a PPO area and uses a non-PPO hospital and a non-PPO physician. (Deductible met)

	Charges	MAP Pays	Employee Pays	Applied to Out-of-Pocket
Hospital	5,000	2,700 (90% of $3,000 PA)	2,300	300
Physician (surgery charge)	1,500	800 (80% of $1,000 PA)	700	200
Total, if QCP Precertifies	6,500	3,500	3,000	500
Total, if not Precertified	6,500	3,250	3,250	500

Example #3

The employee lives in a non-PPO area and uses a non-PPO hospital and a non-PPO physician located outside a PPO area. The charges are within R&C limits.

	Charges	MAP Pays	Employee Pays	Applied to Out-of-Pocket
Hospital	5,000	5,000 (100% allowable expense)	- 0 -	- 0 -
Physician (surgery charge)	1,500	1,350 (90% of $1,500 R&C)	150	150
Total, if QCP Precertifies	6,500	6,350	150	150
Total, if not Precertified	6,500	6,100	400	150

Example #4: When Medicare is Primary

Assume:

- *Deductibles under both Medicare and MAP have been satisfied. In most cases, MAP participants pay the first $180 of covered expenses each calendar year. Expenses applied to the Medicare deductible may also be used to satisfy the MAP deductible.*
- *Medicare's benefit level is 80 percent.*
- *MAP's benefit level is 90 percent.*
- *Physician's charge is $120, which is within R&C.*

	Physician Charge	Medicare Allowance	Medicare Pays	Maximum Charge	MAP Pays	Participant Pays
Physician accepts Assignment	$120	$100	$80 ($100 x 80%)	$100	$10 ($100 x 90% minus Medicare payment)	$10
Physician Does not accept Assignment	$120	$ 95* ($100 x 95%)	$76 ($95 x 80%)	$109.25** ($95 x 115%)	$22.33 ($109.25 minus Medicare payment)	$10.92 ($109.25 minus Medicare pmt. minus MAP pmt.

* Effective Jan. 1, 1992, the Medicare Allowance was reduced to 95 percent for physicians who do not accept the Medicare assignment.

** Effective Jan. 1, 1993, physicians who do not accept the Medicare assignment cannot charge Medicare patients more than 15 percent above the Medicare allowance. The participant is not responsible for the difference between the physician's charge and the maximum charge.

When Coverage Ends or Changes

There are several circumstances in which the coverage you have as an active employee or retiree can end or change.

Termination of Coverage

Coverage for you and your dependents ends if your employment terminates for reasons other than retirement on a service or disability pension, receipt of Long Term Disability benefits, layoff under the terms of the working agreement, provisions of one of the non-management force-adjustment plans, or death. Coverage ends on the last day of the month in which your employment ends.

Coverage also ends on the last day of the month in which:
- You request that your coverage be cancelled for any reason; or
- A required payment is not made; or
- You begin a military leave.

If your coverage ends, your dependents' coverage ends, too. A dependent's coverage will also end on the last day of the month in which:
- A required payment is not made, or
- A dependent no longer qualifies as a dependent (as defined in the Appendix) because of age, a change in full-time student status, marital status, residency or income.

If coverage ends at the end of a month, MAP will not pay benefits for expenses incurred after the end of that month unless the participant is in the hospital on the last day of the month. In that case, only hospital care benefits will be paid for the remaining days of the admission (see the section "Hospital Care Benefits" on page 27). All benefits will end with that admission.

Continued Coverage under COBRA

If you terminate employment for reasons other than gross misconduct, you or your covered dependents may elect to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) by paying 102 percent of the group rate for up to 18 months from the end of the month in which you terminate (see "Your COBRA Rights" on page 68). At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA.

If your dependent no longer qualifies as a dependent under MAP, COBRA coverage may be available.

When You Retire

If you retire from the company on a service or disability pension, the company currently continues coverage for you and your eligible dependents during your retirement through the last day of the month in which you die. However, the company reserves the right, at its discretion, to modify coverage, including reduction or elimination of coverage or requiring retirees to pay all or a greater portion of the cost of coverage.

Currently, retiree coverage is the same as coverage for active employees with the following exceptions:
- Once you or any of your dependents meet the criteria for Medicare eligibility, benefits will be reduced by payments available from Medicare;
- The individual lifetime benefit maximum of $1 million applies to all MAP payments for

each retiree and dependent beginning on January 1 following your retirement;

• For management employees who retire on or after Jan. 1, 1992, MAP will provide secondary coverage when the retiree becomes employed at another company, and the new employer offers a group plan and pays:

- All or any part of the cost of coverage for employees who work 30 or more hours per week, or
- Half the cost of coverage for employees who work less than 30 hours per week, and
- 25 percent or more of the cost of coverage for dependents, including children.

Under this provision, MAP pays normal benefits minus those that would have been paid by the new employer's plan, regardless of the participant's enrollment status.

The cost of retiree coverage is explained on page 18.

Continued Coverage under COBRA

As an alternative to retiree coverage, you or your covered dependents may be eligible to continue coverage under COBRA by paying 102 percent of the group rate for up to 18 months from your pension effective date (see the section "Your COBRA Rights" on page 68). At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA.

If COBRA coverage is elected, MAP currently provides that the retiree coverage applicable at that time, if any, as explained in the previous paragraphs, will begin automatically when COBRA coverage ends for any reason.

Competitor Rule and Benefit Forfeiture

All employees who retire on or after Jan. 1, 1991, may forfeit their rights and their dependents' rights to certain post-retirement benefits if, during the five years following retirement from BellSouth, they provide services to or acquire an interest in a BellSouth competitor. It is important to understand that once such coverage is terminated, it will not be reinstated.

Definition

A competitor of BellSouth or its affiliates is one who, in BellSouth's judgment, is engaged directly or through an affiliate in any line of business in which BellSouth or one or more of its affiliates is engaged, such as, but not limited to: the provision of telecommunications goods or services; the printing, publication, or provision of classified directories; the provision of cellular communications; and the provision of paging goods or services.

As set forth in the BellSouth Medical Assistance Plan; Dental Assistance Plan; Group Life Insurance Plan; and the Death Benefit provisions of the Pension Plan, BellSouth Management Pension Plan or the Personal Retirement Account Pension Plan, a former employee will forfeit entitlement to post-retirement benefits under the foregoing plans if, during the five-year period following the employee's retirement:

a.) The employee acquires ownership of more than 5 percent of any class of stock of, or acquires beneficial ownership of, more than 5 percent of the earnings or profits of a competitor, or

b.) The employee becomes employed by, renders services to, or consults with a competitor, unless the employee's activities on behalf of the competitor make no use, directly or indirectly of: 1) BellSouth proprietary or customer information, or 2) skills that the employee developed or used, or training provided to the employee during the last five years of employment by BellSouth or any of its affiliates.

During the five-year period over which the Forfeiture Provision is applicable, the business activities of BellSouth and its affiliates at the point in time that a former employee acquires an ownership interest in, or becomes employed by, changes assignments with, renders services to, or consults with another business entity will determine whether that entity is a competitor.

Health and welfare benefits are deemed terminated upon the date of occurrence of the forfeiture event, i.e., the date that more than 5 percent ownership interest in a competitor is acquired, or the date that employment with a competitor is begun. Upon learning of a forfeiture event, BellSouth reserves the right to seek the reimbursement of any benefits that were paid following the occurrence of that event.

Request for Benefit Forfeiture Ruling

An employee may file a "Request for Benefit Forfeiture Ruling" with the retiree benefit organization before acquiring an ownership or beneficial interest in another entity or before engaging in any post-retirement employment activity. On the basis of the information included in the request, the employee will receive a binding determination, based on the activity described in the request, as to whether the entity is a competitor, and if applicable, if the activity in question is deemed to be in competition with BellSouth.

If you disagree with the response received from a Request for Benefit Forfeiture Ruling, you may request to have that response reviewed. In order to prevent a possible forfeiture, such a review should be indicated and completed before engaging in the activity at issue.

The review request must be in writing and should be made, within 60 days of the receipt of the response, to the secretary of your company's Employees' Benefit Committee. All supporting information and documents should accompany this submission. The company Employees' Benefit Committee will issue a final, written decision within 120 days.

The addresses of the various company Employees' Benefit Committees are listed below:

- BellSouth Business Systems
- BellSouth Communications, Inc
- BellSouth Communications Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Financial Services Corporation
- BellSouth Telecommunications, Inc.
  Room 18H62 Southern Bell Center
  675 W. Peachtree Street, N.E.
  Atlanta, Georgia 30375

- BellSouth Advertising & Publishing Corporation
- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Mobility Inc
- BellSouth Resources, Inc.
- Sunlink Corporation
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.
  Room 7B09
  1155 Peachtree Street, N.E.
  Atlanta, Georgia 30367-6000

Forfeiture Appeals

If you have your benefit's eligibility terminated under the Forfeiture Provision, you may, on your own behalf or through a representative, have that action reviewed by submitting a written appeal within 60 days of your receipt of the notification of termination or eligibility to the secretary of your company's Employees' Benefit Committee at the address shown above.

If the appeal is denied, you will receive written notice of the Employees' Benefit Committee's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the committee received the appeal.

In some cases, the committee may need more than 90 days to make a decision. In such cases, the committee will notify you in writing within the initial 90-day period and explain why more time is needed. An additional 90 days may be taken to make the decision if the committee sends this notice. The extension notice will show the date by which the committee's decision will be sent. If the committee does not give its decision within the designated time span, the appeal is considered denied.

If your appeal to the Employees' Benefit Committee is denied, or deemed denied where no reply is received within 90 days, or within 180 days if an extension was requested, you may challenge such a denial by submitting a written appeal to the secretary of the BellSouth Corporation Employees' Benefit Claim Review Committee at the following address:

Room 1927
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000

Such an appeal must be submitted in writing within 60 days after the receipt of the Employees' Benefit Committee's denial notification, or if no denial is received, within 60 days of the date that the original appeal was deemed to be denied. The Employees' Benefit Claim Review Committee will conduct a review and issue a determination within 60 days after receipt of the appeal. In some cases, the Claim Review Committee may need more than 60 days to make a decision. In such cases, the Claim Review Committee will notify you in writing within the initial 60-day period and explain why more time is needed. The Employees' Benefit Claim Review Committee may then have 60 days more, or a total of 120 days, in which to make its decision.

The Employees' Benefit Claim Review Committee will issue a final written decision that will include specific reasons for the decision. If the Employees' Benefit Claim Review Committee does not issue its decision within the appropriate time span, the appeal is deemed to be denied. In submitting an appeal either to the Employees' Benefit Committee or the Employees' Benefit Claim Review Committee, you are entitled to include in a written statement of the issues and any other documents in support of the appeal. All material provided to either committee will be carefully considered in the determination.

BellSouth has delegated to the company Employees' Benefit Committees and the BellSouth Corporation Employees' Benefit Claim Review Committee the duty to administer the appeal of benefit eligibility terminations under the Forfeiture Provision. The BellSouth Employees' Benefit Claim Review Committee has the discretion and authority to interpret and to enforce the Forfeiture Provision, and its determinations and interpretations are final and conclusive

As a participant in the various benefit plans subject to the Forfeiture Provision, you have further rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Those rights are described in detail in the summary plan descriptions issued for each affected plan.

If You Become Disabled

If you become disabled before retirement and are eligible to receive benefits under one of the company's Long-Term Disability (LTD) plans, MAP coverage for you and your dependents will continue.

LTD coverage is currently the same as for active employees with the following exceptions:

- Once you or any of your dependents meet the criteria for Medicare eligibility, benefits will be reduced by payments available from Medicare.
- The individual lifetime benefit maximum of $1 million applies to you and each dependent beginning on January 1 following your eligibility for LTD benefits.
- There are no substance abuse rehabilitation benefits for expenses incurred by you or your dependents on or after the first day of the month following your eligibility for LTD benefits.

The company currently pays the full cost of coverage for you and your Class I dependents while you are LTD-eligible with regular contributions required for all other dependents. However, the company reserves the right to modify coverage, at its discretion, including reduction, elimination of coverage, or requiring you to pay all or a portion of the cost of coverage, subject to applicable collective bargaining agreements.

Continued Coverage under COBRA

As an alternative to LTD coverage, you or your covered dependents may be eligible to elect to continue coverage under COBRA by paying 102 percent of the group rate for up to 18 months from the first of the month following the month in which you became disabled (see the section "Your COBRA Rights" on page 68). If you are receiving Social Security disability benefits, and if you qualify, the 18-month period may be extended to a 29-month period by paying 150 percent of the group rate during the 19-29 months. At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA

If COBRA coverage is elected, MAP currently provides that the coverage applicable at that time for LTD-eligibles (explained above), if any, will begin automatically when COBRA coverage ends for any reason.

When You Die

If you die while you are an employee or retiree, MAP coverage may continue as follows:

- If you have a surviving spouse, MAP coverage may continue for your surviving spouse and Class I and Class II dependents. Sponsored dependents do not qualify for surviving spouse benefits, and their coverage will end on the last day of the month in which you die.
- If you do not have a surviving spouse, MAP coverage may continue for your Class I dependents only. Coverage for all other dependents will terminate on the last day of the month in which you die.

The company provides full coverage for the first six months. Following the last day of the sixth month after your death, your spouse or

Class I dependents may continue coverage by paying 100 percent of the group rate (individual, two-party, or family).

Coverage for a surviving spouse and Class I and Class II dependents of a deceased **active** employee is the same as for active employees except:

- The coverage is available only for your spouse, Class I, and Class II dependents who are covered on the day of your death. Your spouse cannot enroll any new Class I or Class II dependents.
- If there is no surviving spouse, the coverage is available only for the Class I dependents who are covered on the day of your death until they would normally age out of the plan according to current rules.
- There is an individual lifetime benefit maximum of $1 million which applies to all MAP payments beginning January 1 following each participant's (your spouse's and each dependent's) 65th birthday.

Coverage for a surviving spouse and Class I and Class II dependents of a deceased **retired** employee is the same as for retired employees except:

- The coverage is available only for your spouse, Class I, and Class II dependents who are covered on the day of your death. Your spouse cannot enroll any new Class I or Class II dependents.
- If there is no surviving spouse, the coverage is available only for the Class I dependents who are covered on the day of your death until they would normally age out of the plan according to current rules.

The company reserves the right to modify coverage, at its discretion, including reduction, elimination of coverage, or requiring a surviving spouse to pay all or a greater portion of the cost of coverage.

Continued Coverage under COBRA

As an alternative to surviving spouse/surviving Class I dependent coverage after the death of an active employee, your covered dependents may elect to continue coverage under COBRA by paying 102 percent of the group rate for up to 36 months (see "Your COBRA Rights" on page 68). At the appropriate time, the company will provide your dependents with information on how to elect continued coverage under COBRA. After the death of a retiree, your covered dependents may, under certain circumstances, elect COBRA coverage for up to 36 months from the date of your retirement.

If COBRA coverage is elected, your surviving spouse and Class I and Class II dependents will automatically be eligible for coverage which MAP then provides for the survivor coverage applicable at that time, if any, according to company policy (see above) when COBRA coverage ends for any reason.

Leave of Absence

In the case of an approved leave of absence, MAP currently provides that you can continue coverage for yourself and your dependents for the duration of the approved leave by paying the full cost of coverage unless the leave is an approved Care of Newborn Child Leave or Dependent Care Leave. In that case, the company will pay the full cost of MAP coverage for up to six months during the leave in any two-year period if you were eligible to receive company-paid coverage prior to the Care of Newborn Child or Dependent Care Leave.

If you go on a leave that qualifies under the Family Medical Leave Act of 1993 (FMLA), you may be eligible for up to 12 weeks of

company-provided medical coverage. Contact the Benefit Office for details.

For persons considering a Sabbatical Leave of Absence or participation in the Career Alternative Plan (CAP), please contact your Benefit Office for coverage information.
Under MAP, a leave to enter military service is not considered an approved leave. If you enter military service, coverage for you and your dependents will end on the last day of the month in which you are an active employee.

If you are planning to go on an approved leave of absence (other than military leave), and you are also an eligible dependent of an active employee, you may request to transfer your medical coverage as an active employee to coverage as a dependent of an active employee without a break in coverage. Your request should be made before your leave of absence begins.

The company reserves the right to modify coverage, at its discretion, including reduction or elimination of coverage, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

If you are a MAP participant on an approved leave of absence and do not return to work at the termination of your leave, you or your dependents may elect to continue coverage under COBRA by paying 102 percent of the group rate as long as you continued coverage while you were on leave (see the section "Your COBRA Rights" on page 68)

COBRA coverage is only available for up to 18 months from the day your leave began.

Extended Medical Coverage

Non-management employees covered under MAP, who are not eligible for a company service or disability pension and are either laid-off or leave the company under the provisions of a force-adjustment plan, may continue coverage for up to 12 months (based on the terms of their force-adjustment plan) beginning on the first day of the month following layoff/ separation. The period of company contributions for continued coverage is currently based on net credited service as follows:

- Former employees with five or more years of net credited service will continue to receive current levels of company-paid medical coverage for up to six months. The former employee may then continue coverage for the next six months by paying 100 percent of the monthly group rate.
- Former employees with more than one year but less than five years of net credited service will receive three months of the current level of company-paid coverage with an option to pay 100 percent of the group rate for an additional nine months of coverage.
- An employee with less than one year of service may elect to pay 100 percent of the group rate for coverage for 12 months.

The continued coverage will be the same as the coverage then provided to active employees. Therefore, any changes in benefits or contributions for active employees will be applied to participants in this extended medical coverage program. The company reserves the right to modify coverage, at its discretion, including reduction, elimination, or requiring former employees to pay all or a greater portion of the cost of coverage, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

Once the former employee's right to extended coverage ends, the former employee or his/her covered dependents may be eligible to elect to continue coverage under COBRA for up to an additional six months by paying 102 percent of the group rate (see "Your COBRA Rights" on page 68). At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA.

Conversion Rights

If coverage terminates either for you or for one of your dependents, and COBRA coverage is not elected, you currently may be able to convert coverage to a non-group policy issued by Blue Cross and Blue Shield (see page 70).

This non-group coverage currently provides hospital, limited surgical, and medical benefits different from those MAP provides. No medical examination will be required. You must file a written request for this coverage directly with Blue Cross and Blue Shield within 31 days after your coverage ends unless you purchase COBRA coverage.

If you elect COBRA coverage, and conversion rights are otherwise generally available under MAP when your COBRA coverage terminates, you will have 31 days from the date your COBRA coverage ends to convert to a non-group policy.

Your COBRA Rights

In 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA), was enacted. COBRA is a federal law that requires that most employers sponsoring group health plans offer employees and their dependents the opportunity for a temporary extension of health coverage ("COBRA coverage") at 102 percent of group rates in certain instances where coverage would otherwise end or change. The information in this section is intended to summarize your rights and obligations under COBRA. You, your spouse, and your other covered dependents should read this section carefully.

If you are an active regular employee or a regular employee on approved leave of absence, covered by the BellSouth Medical Assistance Plan or an alternative Health Maintenance Organization (referred to in this section as "the plan"), you have a right to choose COBRA coverage for yourself and your covered dependents if you lose your coverage, or if your coverage changes because of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in hours.

If you are the spouse of an employee covered by the plan, you have the right to choose COBRA coverage for yourself and your covered dependents if your coverage ends or changes due to any of the following events:

- The death of your active spouse;
- The death of your retired spouse, under certain circumstances, if within 18 months of your spouse's retirement;
- Termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;

- Divorce from your active spouse; or
- Divorce from your retired spouse, under certain circumstances, if within 18 months of your spouse's retirement.

A covered dependent has the right to elect COBRA coverage for himself/herself if coverage ends or changes for any of the following events:
- The death of a covered active employee;
- The death of a retired employee, under certain circumstances, if within 18 months of the employee's retirement,
- The termination of the covered employee's employment (for reasons other than gross misconduct) or a reduction in the covered employee's hours;
- Divorce of an active employee;
- Divorce of a retired employee, under certain circumstances, if within 18 months of the employee's retirement; or
- The dependent ceases to be a dependent under the provisions of the plan.

Under the law, the employee or a family member has the responsibility to inform the Benefit Office within 60 days after losing coverage because of a divorce or after a dependent loses dependent status (see Appendix for definition). The company has the responsibility to notify the appropriate Benefit Office of the employee's death or termination of employment.

When the Benefit Office is notified that one of these events has happened, you will be notified regarding COBRA coverage. Under the law, you have 60 days from the later of the following two dates to elect COBRA coverage:
- The date you would lose coverage, or coverage would change because of one of the events described above, or
- The date the COBRA Election Form is sent to you by the Benefit Office.

If you do not choose COBRA coverage, your coverage will end or change in accordance with MAP's provisions.

If you choose COBRA coverage, the company is required to give you coverage identical to the coverage provided under the plan to active employees in similar situations, as of the time coverage is being provided. The law requires that you be allowed the opportunity to maintain COBRA coverage for 36 months unless you lost coverage or coverage changed because of a termination of employment or reduction in hours. In those cases, the required COBRA coverage period is 18 months; however, the 18-month period may be extended to a 29-month period if you were classified as disabled by the Social Security Administration as of the last day of active employment.

The law also provides that your COBRA coverage may be cut short for any of the following reasons:
- The company no longer provides any group health coverage to any of its employees;
- The charge for your COBRA coverage is not paid on a timely basis;
- You become covered under another group medical plan, unless the new coverage contains an exclusion or limitation which affects the COBRA-covered individual due to a pre-existing condition;
- You become entitled to Medicare.

You do not have to show that you are insurable to elect COBRA coverage. However, under the law, you will have to pay up to 102 percent of the group rate for your COBRA coverage during your 18- or 36-month period. In addition, if you are receiving Social Security disability benefits, the cost of your COBRA coverage during your 19-29 months of extended coverage will be 150 percent of the group rate.

The law also states that at the end of the maximum available continuation coverage period (18, 29, or 36 months), you must be allowed to convert your coverage to the individual health plan then provided under MAP to the extent, and under the same terms and conditions, that an individual conversion right otherwise is generally available to active employees in similar situations when your COBRA coverage terminates.

Employee Assistance

Employee Assistance (EA) is available to certain participating companies and designated divisions of other companies. These participating companies may be changed from time to time. You should contact your Human Resources office if you have any questions about whether your employer participates in EA.

EA services are available to employees and their families regardless of whether they enrolled in this medical plan or an alternative medical plan such as an Health Maintenance Organization (HMO).

EA offers services for employees and their families who are experiencing personal problems. The company recognizes that a wide range of medical/behavioral problems, not directly related to job functions, can affect an employee's job performance. These problems may include physical illness, mental or emotional illness, alcohol or other drug abuse, or concerns over financial, marital or other family difficulties. EA is also designed to provide assistance to supervisors and managers as they respond to employees who are experiencing declining job performance.

Communications between employees and an EA counselor are kept strictly confidential, except to the degree necessary to protect the safety of the employee and/or others, to protect the security of company property, or to protect the company's interest if any employee involves the EA in legal, administrative or arbitration proceedings against the company. Parameters of confidentiality will be clearly outlined prior to any session with the EA staff.

Participation in the program will not jeopardize your job security or advancement opportunities. If you need assistance in these or other personal matters, contact your company EA coordinator or your supervisor.

Should your request for services be denied, you may request to have that decision reviewed. The review request must be in writing and be made, within 60 days of the receipt of the response, to the secretary of the Employees' Benefit Committee. All supporting information and documents should accompany this submission. The company Employees' Benefit Committee will issue a final, written decision within 120 days.

Committee addresses are:

- BellSouth Advertising and Publishing Corporation

Room 7B09
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth CommunicationsSystems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Telecommunications, Inc.

Room 18H62 Southern Bell Center
675 W. Peachtree Street, N.E.
Atlanta, Georgia 30375

If the appeal is denied, you will receive written notice of the Employees' Benefit Committee's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the committee received the appeal.

If your appeal to the Employees' Benefit Committee is denied, or deemed denied where no reply is received within 90 days, you may challenge such a denial by submitting a written appeal to the secretary of the BellSouth Corporation Employees' Benefit Claim Review Committee at the following address:

Room 1927
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000

Such an appeal must be submitted in writing within 60 days after the receipt of the Employees' Benefit Committee's denial notification, or if no denial is received, within 60 days of the date that the original appeal was deemed to be denied. The Employees' Benefit Claim Review Committee will conduct a review and issue a determination within 60 days after receipt of the appeal.

Other Information

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As ERISA requires, this section provides additional information about your benefits as well as a statement of your rights and protection under this law.

Funding

BellSouth currently provides for the payment of MAP benefits through one of four established trusts: two for management employees and two negotiated trusts that cover non-management employees. These trusts fund post-retirement and active health benefits for employees and their covered dependents. The trusts also accept participant contributions for medical coverage. In addition, to meet MAP's obligations, the participating companies make periodic contributions.

The trustee is:

NationsBank
Master Trust - Southeast
600 Peachtree St., N.E. - 7th Floor
Atlanta, Georgia 30308

Benefit payment checks that are not cashed within 180 days after the date of the check will be considered null and void, and the benefit so paid will be forfeited. All forfeited amounts will be re-deposited into the trust from which paid. Any benefit so forfeited may be reinstated by filing a claim for the forfeited amount and satisfactorily demonstrating entitlement to the payment.

Name and Type of Plan

The name of this plan is the Medical Assistance Plan. The plan is classified under the ERISA as a "welfare plan," because it provides medical, surgical, and hospital benefits.

Plan Administrator

The plan administrator is BellSouth Corporation, Room 7B09, 1155 Peachtree Street, N.E., Atlanta, Georgia 30367-6000.

BellSouth has delegated responsibility for handling plan administrative services for each participating company as follows:

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth Communication Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Financial Services Corporation
- BellSouth Telecommunications, Inc.

ACTIVES:
Secretary
Employees' Benefit Committee
Suite 1400
3000 Riverchase Galleria
Birmingham, Alabama 35244
Telephone:
Local Service provided by:
Southern Bell 780-2029
South Central Bell 1-557-6179
Any other company 0-205-733-3001, call collect

RETIREES:
Operations Manager - Retiree Benefits
18H62 Southern Bell Center
675 W. Peachtree Street, N.E.
Atlanta, Georgia 30375
Telephone:
Local Service provided by:
Southern Bell 780-2025
South Central Bell 1-557-6666
Any other company 1-800-842-1558

- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Resources, Inc.
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.
- Sunlink Corporation

Secretary
BellSouth Enterprises Employees' Benefit Committee
Room 7B09, 1155 Peachtree Street, N.E.
Atlanta, Georgia 30309
(404) 249-4175

- BellSouth Advertising and Publishing Corporation

Assistant Secretary
BellSouth Enterprises Employees' Benefit Committee
59 Executive Park South, N.E.
Atlanta, Georgia 30329
(404) 982-7027

- BellSouth Cellular

Assistant Secretary
BellSouth Enterprises Employees' Benefit Committee
Suite 600
5600 Glenridge Drive
Atlanta, Georgia 30342
(404) 847-3650

Plan Administration

BellSouth has delegated to Blue Cross and Blue Shield of Alabama (and United HealthCare, Inc., with respect to QCP) the duty to administer all claims for plan benefits for all participating companies. The Administrative Service Agreement between BellSouth Corporation and Blue Cross and Blue Shield of Alabama governs the operation of the plan at all times. This agreement designates Blue Cross and Blue Shield of Alabama as the claims administrator. Blue Cross and Blue Shield of Alabama and, with respect to QCP, United HealthCare, Inc., have complete discretionary authority to determine benefits under the plan and to interpret the terms and provisions of the plan. Their determinations and interpretations are final and conclusive.

As a contract holder receiving plan benefits, authorization is given to all payees (hospital, physicians, labs, etc.) receiving money in connection with this plan to release medical information to the plan administrator or a designated auditor on behalf of you and your dependents.

Subrogation

Subrogation is the right of an individual/entity that has paid another individual/entity's legal obligation to recover that payment from that individual/entity. MAP has a subrogation interest in any recovery that you or a covered dependent receives or could claim from a third party responsible for an injury or illness. In other words, to the extent that MAP has paid claims related to such an injury or illness, it has the right to recover the amounts of these claims from the third party or from any payment you receive from the third party.

You are required to provide the company with any information it may need to pursue its subrogation rights, and your receipt of any benefits under this plan is subject to the company's subrogation rights. Failure to cooperate in supplying the claims administrator with necessary information could result in the suspension of plan benefits.

Notification of Denial of Benefits

If a request for plan benefits is denied, either in whole or in part, you or your dependents will receive written notification from Blue Cross and Blue Shield of Alabama. Notification will include:

- The specific reason(s) for the denial;
- Specific reference to pertinent plan provisions on which the denial is based;
- A description of any additional material or information necessary for the individual to perfect the benefit request and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if you, your dependent, or a duly authorized person representing you or your dependent, wish to submit the benefit request for review.

If you do not hear from Blue Cross and Blue Shield of Alabama within 90 days after your benefit request has been submitted according to the procedures outlined in this booklet under "How to File a Claim" on page 57, your request is considered denied.

Review Procedures

If a request for benefits is denied, or you or your dependents feel you have been treated unfairly with respect to the plan, you, your dependent, or a duly authorized person may request a review of the denied claim or other action within 180 days after you receive notification of the decision. You may call Blue Cross and Blue Shield of Alabama or submit a written request for review of any denied benefit payment or other disputed matter, accompanied by any additional documents or records to support the review.

Review requests should be mailed to:
BellSouth Review Facilitator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

ERISA Appeal Procedures

If your request for review results in the denial being upheld, you, your dependent, or a duly authorized person may request an ERISA appeal. You must submit a written request for appeal within 100 days after your receipt of notification of the review decision. Written request for an appeal of any denied benefit payment or other disputed matter should be sent directly to Blue Cross and Blue Shield of Alabama and should be accompanied by any additional documents or records to support the appeal. The person sending the request has the right to:

- Review pertinent plan documents which may be obtained by following the procedures described in this section;
- Send Blue Cross and Blue Shield of Alabama a written statement of the issues and any other documents in support of the request for benefits or other matter regarding the appeal.

Appeal requests should be mailed to:
BellSouth ERISA Appeals Coordinator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

Blue Cross and Blue Shield of Alabama is responsible for coordinating the appeals process under ERISA for all denials reported on the "Claims Report" except those involving enrollment status. The "Claims Report" will direct the claimant to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (as shown under "Plan Administrator" on page 72) in any case involving a denial based on ineligibility of the claimant.

If any part of a denial is based on a decision by United HealthCare, they will re-evaluate their decision and provide a final determination to Blue Cross and Blue Shield of Alabama for use in notification to the claimant.

Likewise, Blue Cross and Blue Shield of Alabama will re-evaluate any part of the denial that is based solely on its decision and make a final determination. Because this determination is final, it is important that you forward all information to Blue Cross and Blue Shield of Alabama for consideration in its review of your appeal

In all appeal cases, a response will be provided to the claimant within 60 days after the appeal is received. As a participant in the plan, you may have further rights under ERISA (see "Your Rights Under ERISA" on page 76). In this respect, BellSouth, the plan administrator, retains the right to interpret the plan's provisions and to make final decisions regarding covered expenses and eligibility.

Legal Service

Service of legal process in a cause of action with respect to any and all provisions of the Administrative Service Agreement should be directed to the BellSouth ERISA Appeals Coordinator (see address under "ERISA Appeal Procedures" on page 74).

Service of legal process concerning the plan may also be directed to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager or to the Trustee (see "Funding" on page 71).

Plan Records

The Medical Assistance Plan and all its records are kept on a calendar-year basis.

Plan Identification Numbers

The plan is identified by the following numbers under Internal Revenue Service rules:

# 58-1533433	Employer Identification Number assigned by the IRS
# 522	Plan number assigned by the company

Plan Continuance

The company currently intends to continue the Medical Assistance Plan for active and former employees and retirees under the terms of the plan, but reserves the right to amend or terminate it at any time, subject to any applicable collective bargaining agreements.

The benefits described in this booklet reflect the provisions of the Medical Assistance Plan as outlined in the current collective bargaining agreements, if any, between the participating companies and the various unions representing employees of those companies in collective bargaining units. Copies of these collective bargaining agreements are distributed or made available to employees covered by them upon request.

Plan Documents

This booklet is a summary of the Medical Assistance Plan and does not attempt to cover all details. Specific details are contained in the Administrative Service Agreement between Blue Cross and Blue Shield of Alabama and BellSouth Corporation which legally governs the operation of the plan. Plan participants are entitled to examine, free of charge, plan contracts and documents, in accordance with, and as defined by ERISA, including the Administrative Service Agreement, the annual report of plan operations, and other such documents and reports maintained by the plan or filed with a federal government agency.

These contracts and documents are available for review during normal working hours at your plan administrator's office. If you are unable to examine these contracts and documents there, you should write to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (see "Plan Administrator" on page 72) specifying the contracts and documents to be examined and at which company work location you wish to examine them. Copies of such contracts and documents will be made available for examination at that work location within 10 days of the date the request was received.

At any time, you may request copies of any plan contracts and documents by writing to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (see "Plan Administrator" on page 72). You will be charged a reasonable fee for copies.

Your Rights Under ERISA

MAP benefits are covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was signed into law for the purpose of protecting your rights under employee benefits plans. The law does not require a company to provide benefits, but it sets standards for benefits a company wishes to offer and requires that you be given an opportunity to learn about your rights under the law.

It is your right to know as much as possible about your benefits. This booklet is one way to keep you informed. As a participant in MAP, you are entitled to certain rights and protection under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, as defined by ERISA, including contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S.Department of Labor.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. A reasonable charge may be made for such copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, "fiduciaries" of the plan, have a duty to do so prudently and in your interest and in the interest of other plan participants according to the plan's provisions. No one, including your employer and your union, may fire or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your request for a benefit under this plan is denied, in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to formally appeal a denial for review and reconsideration (see "Review Procedures" on page 74).

Under ERISA, there are steps you can take to enforce the rights outlined in this section. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a request for benefits which is denied or ignored, in whole or in part, you may file a legal action to recover these benefits. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.Department of Labor, or you may file suit in a federal court. The court will decide who will pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs

and fees. For example, the court may order you to pay costs and fees if it finds your request to be frivolous.

If you have any questions about this statement of your rights, or your rights under ERISA, contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor.

Appendix

Definitions

Some words or phrases used in this booklet may not be familiar to you; however, they have a very specific meaning when applied to MAP. To help you understand how MAP works, it is important for you to know what the following terms mean as used in this booklet.

Alternate Benefits. Certain expenses covered by MAP that must be precertified by QCP. Alternate benefits are designed to provide you with options to hospital stays and other medical care or treatments. Alternate benefits include coverage for:

- Birthing centers/nurse midwives;
- Extended care/skilled nursing facilities;
- Home health care;
- Hospice care;
- Partial hospitalization for a substance abuse rehabilitation program;
- Expenses due to special arrangements or treatments when medically appropriate;
- Private duty nursing.

Ambulatory Surgical Facility. An institution, either free-standing or a part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures where a patient is admitted and discharged within a brief period (generally not exceeding 24 hours).

The following are not considered ambulatory surgical facilities:

- An office maintained by a physician or group of physicians for the practice of medicine, or a surgical suite as part of their office;
- An office maintained for the practice of dentistry;
- A facility primarily engaged in performing abortions.

Appeal. A written request mailed within 100 days after receipt of notification of the review decision regarding any denied claim (either in whole or in part) or other disputed matter (see "ERISA Appeal Procedures" on page 74).

Birthing Center. A facility used for the normal delivery of children, operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Carve Out. When MAP is the secondary plan, the claims administrator determines the charges covered under MAP and subtracts the payment that would have been made by the primary plan, whether or not the eligible participant is enrolled in the primary plan (see the sections "Coordination of Benefits" on page 51 and "Medicare" on page 56).

Claims Administrator. An organization that processes medical claims at the request of the company. The claims administrator for MAP is Blue Cross and Blue Shield of Alabama.

Claims Report. A statement provided by Blue Cross and Blue Shield of Alabama that describes the status of a claim. It includes information such as which expenses MAP covers, applies the deductible to, pays, or excludes. Many medical plans refer to this report as an "Explanation of Benefits" or "EOB."

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, was signed into federal law April 7, 1986. COBRA requires that group health coverage be continued under certain circumstances when coverage otherwise would end or change (see the sections "When Coverage Ends or Changes," page 61, and "Your COBRA Rights," page 68).

Coordination of Benefits (COB). COB applies when a participant is eligible for coverage under two or more group health plans. COB laws and MAP provisions determine which plan must consider the expenses first. That plan is called the PRIMARY plan. The plan that considers expenses after the primary plan is called the SECONDARY plan. There is no COB between BellSouth companies covered under MAP or other BellSouth provided plans, nor does MAP coordinate benefits with any HMO.

Copayment. The dollar amount a participant pays when using various programs, e.g., Mail Order Prescription Drug Program, PPO physician office services, etc.

Cosmetic Surgery. Any surgical procedure that primarily improves or changes appearance but does not primarily improve bodily functions or correct deformities resulting from disease, trauma, or congenital anomalies. Improvement of bodily function does not include improvement of psychological effects caused by physical defects or conditions. Cosmetic surgery is not covered under MAP.

Covered Charge/Covered Expense. The charge associated with a covered medically-necessary service, supply, or procedure incurred by a participant for a non-occupational illness or injury, that is eligible for consideration based on Reasonable and Customary (R&C) limits, Payment Allowance limits, or Negotiated Fees established under MAP and not excluded by any other provision of MAP. For example, amounts above R&C limits are not covered expenses.

Custodial Care. Care primarily for the purpose of providing room and board (with or without routine nursing care, training in personal hygiene, other forms of self-care or supervisory care by a physician) for a person who is mentally or physically disabled. Custodial care is not covered under MAP.

Deductible. The amount of covered expenses you pay during the calendar year before MAP will begin paying benefits. The deductible will be applied in the order in which claims are processed by the claims administrator. The individual deductible is $180 and applies each calendar year to you and each of your covered dependents. For example, you have $300 of covered expenses to be filed under MAP and have not filed any other claims during the calendar year. The claim will be processed as follows:

Covered Charges:		$300
Less Calendar Year Deductible:		$180
MAP Pays	$120 (x 90%) =	$108

The family deductible will be met when covered charges applied toward your deductible and/or other family members' individual deductibles total $425, or when two $180 individual deductibles have been met, whichever occurs first.

Dependent. A family member who qualifies for MAP coverage by meeting the following criteria:

• Class I Dependents. Your spouse and your unmarried children living with you, until the end of the year in which they reach age 19 or, if they are enrolled as full-time students, until the end of the year in which they reach age 23; or an unmarried child who is physically or mentally disabled and fully dependent on you for support. In order to remain a Class I dependent, a child must be classified as disabled before losing Class I status by reaching the age

of 19, or 23 if a full-time student. A child also can lose Class I status before age 23 if that child ceases to be a full-time student.

If a Class I dependent child is certified as disabled, that child will continue as a Class I dependent as long as he/she qualifies as disabled (regardless of age) as described under "Disabled Children Certification Requirements" on page 15.

For divorce situations, contact your Benefit Office.

Children include your own children, legally adopted children, and children placed in your home for the purpose of adoption. Stepchildren or children for whom you or your spouse are court-appointed permanent legal guardians also qualify for Class I dependent status if they live with you. Other court-appointed or approved relationships may qualify after being in existence for a 12-month period. Contact your Benefit Office to determine if they qualify. Wards of the state and foster children are not eligible.

• Full-Time Student. A participant's unmarried child age 19 to 23 who attends an accredited high school, college, university or other bonafide educational institution, such as nursing school, trade school, etc., that has a curriculum for full-time students. Correspondence schools, night schools or schools requiring less than full-time attendance are not acceptable. Typically, the courses generate the following credits for full-time students:

Four-Year Institution:	8 hours/quarter, 12 hours/semester
Junior College:	12 hours/quarter

Some educational institutions, etc., may require more or less hours to qualify for a full-time student status. The student must satisfy the eligibility requirements for full-time student status of the college institution which he/she is attending to be eligible for coverage.

• Class II Dependents. Your unmarried children (other than Class I dependents), your unmarried grandchildren, your unmarried brothers/sisters, and your or your spouse's parents and grandparents if they have lived with you or in a household owned, leased, or rented entirely by you in the vicinity for at least six months before applying for coverage.

Vicinity means the same town or city and zip code area as your residence or within a distance where you can provide daily care and supervision of the dependent. However, a Class II dependent who is a full-time student does not have to live in the vicinity.

To qualify for coverage, the total income of a Class II dependent (not including any support you provide) must be less than $8,800 from all sources, including Social Security, during the calendar year in which he/she is covered.

• Sponsored Child. An unmarried child, age 19 or older, who is not a full-time student. You may sponsor such a child for coverage until the end of the year in which he/she reaches age 23, whether or not the child resides with you and regardless of his/her income. You must pay the full cost of this coverage. To apply, contact your Benefit Office.

Durable Medical Equipment (DME). Equipment approved by the claims administrator as medically necessary to diagnose or treat an illness or injury, to improve the functions of a malformed body appendage, or to prevent or retard further deterioration of the patient's medical condition.

To qualify as DME, the item must also be:
- Made to withstand repeated use;
- Mainly for a medical purpose, not mainly for comfort or convenience;
- Useful only if the participant is sick or injured;
- Ordered and/or prescribed by a physician for use in the participant's home; and
- Related to the patient's physical disorder.

Eligible Charge. See "Covered Charges" on page 21.

Emergency. A sudden, serious, and unexpected onset of a medical condition having symptoms so acute and of such severity as to require immediate medical attention to prevent permanent danger to one's health or other serious medical results, impairment to bodily function, or permanent lack of function of bodily organs or appendages. An emergency may or may not require hospital admission, and treatment must be provided by a physician or surgeon.

Employee. Any regular full-time or regular part-time employee so classified by the Company for payroll purposes. (See page 14.)

ERISA. The Employee Retirement Income Security Act of 1974, as amended. This act provides protection and guarantees for employees and the beneficiaries of employees covered by certain group benefit plans.

Exclusion. Any service, supply, treatment, circumstance, or expense not covered by MAP.

Experimental or Investigative. A particular treatment, procedure, facility, equipment, drug/drug use, supply, or service is experimental or investigative unless it is an approved means of treatment and as effective as any alternative means of treatment as determined by:
- Medicare; and
- Blue Cross and Blue Shield Association; and
- Blue Cross and Blue Shield of Alabama.

Extended Care/Skilled Nursing Facility. An institution that provides for intermediate skilled nursing care for the chronically ill, not including custodial care. Under the direction of a staff physician, these facilities offer 24-hour skilled nursing care and are designed to provide recuperative care, not the acute care hospitals are designed to provide. For these services to be eligible for reimbursement under MAP, these services must be precertified by QCP (see "The Quality Care Program" on page 24).

Facility Charges. Charges for services provided in and billed by facilities such as hospitals or ambulatory surgical facilities. Charges billed by a physician will not be considered as facility charges.

Generic Drug. A drug which meets the same federal standards for safety, purity, strength, and quality as a brand name or trademark drug.

Home Health Care. In-home care or treatment that is provided as an alternative to hospitalization. To be eligible for reimbursement under MAP, Home Health Care must be precertified by QCP (see "The Quality Care Program" on page 24).

Hospice. An institution or organization designed to provide care for the terminally ill. Use of this service requires precertification by QCP (see "The Quality Care Program" on page 24).

Hospital. A legally constituted institution that provides 24-hour nursing services and maintains on its premises the equipment, space, and supplies needed to provide diagnosis and treatment of ill or injured people by or under the supervision of a staff of physicians.

Psychiatric hospitals that are accredited by the Joint Commission on the Accreditation of Health Care Organizations are considered to be hospitals under MAP.

Convalescent homes, nursing homes, half-way facilities, hotels, school/college infirmaries, and other facilities that primarily provide nursing care, custodial care, or rest care, or care for the aged do not qualify as hospitals under MAP.

Long-Term Disability (LTD) Eligible. A former employee who is not pension eligible but is eligible to receive benefits under a company long-term disability plan whether or not LTD payments are actually being received.

Medical Assistance Plan (MAP). The BellSouth medical plan, as revised effective Jan. 1, 1993, and referred to as "MAP" or the "plan."

Medically Necessary. The use of medical services or supplies that are necessary to safeguard the patient's life or health or to treat illness/injury. To be medically necessary (as determined by Blue Cross and Blue Shield of Alabama or QCP), the services or supplies must meet all of the following criteria:

- Be appropriate and necessary for diagnosis or treatment of the participant's condition, disease, ailment or injury;
- Be provided for the diagnosis or direct care of the medical condition;
- Be used in accordance with standards of good medical practice accepted by the organized medical community;
- Not be solely for the convenience of the patient, his/her family, his/her physician, or another provider of services;
- Not be experimental, exploratory, or investigative;
- Be performed in the appropriate medical setting to meet the patient's condition.

Medicare. A program sponsored by the Social Security Administration that provides medical benefits for certain individuals age 65 and older, and for certain disabled people under age 65.

Nurse Midwife. A person who is certified by the American College of Midwives or licensed/certified as a nurse midwife in the states requiring such license or certification. To be eligible for reimbursement under MAP, nurse midwife services must be precertified by QCP (see "The Quality Care Program" on page 24).

Occupational Illness or Injury. Expenses due to an occupational illness or injury covered by Workers' Compensation are not covered by MAP. However, PPO providers who have agreed to provide services for occupational illness or injury will be reimbursed at 100 percent of the PPO negotiated fees or the applicable State Worker's Compensation Fee. All other providers of services related to occupational illness or injury will be reimbursed according to applicable state Workers' Compensation laws.

Out-of-Pocket Limit. See "How MAP Works" on page 20.

Partial Hospitalization. When a patient is admitted to the hospital under an approved treatment or rehabilitation program for substance abuse, and the daily stay is for less than 24 hours. To be eligible for reimbursement under MAP, Partial Hospitalization must be precertified by QCP (see "The Quality Care Program" on page 24).

Participants. The following individuals are plan participants:

- Active regular employees and their enrolled dependents;